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Family Physician					
Referred by or Request for Consult by					
How Did You Hear Of U	s?				
Patient Name					
First	Middle	Last		Date of birth	
Address	City_		State	Zip	
Male Female	Email Address		SSN		
Home ()	Cell ()	Work (	()		
Employer	mployer Can Message be left at above numbers?				
Spouse's Name	Phone Number ()				
Emergency Contact If Different From Spouse		Phone ()			
<u>A</u>	greement for Examination	on And/Or Treat	t <u>men</u> t		
understand I have t	consent to be examined an	decisions involvi	ing my hea	lth care. I	
do consent to such r physician.	outine diagnostic procedu	ures deemed nec	essary by	my	
Printed Name of Responsi	ble Party Signature of Re	sponsible Party	Date	<u> </u>	